The CHILD

Monthly Bulletin

Conservation of the Medically Handicapped Child

☆ ☆ ☆

The Family Physician Cooperates With the Health Department

☆ ☆ ☆

Home-Saving Through Housekeeper Service

☆ ☆ ☆

Child-Labor Standards and Defense Contracts

U. S. DEPARTMENT OF LABOR
CHILDREN'S BUREAU

OCTOBER 1940

THE CHILD

MONTHLY BULLETIN

Volume 5, Number 4 October 1940

CONTENTS

ETIN

1940

Conservation of the Medically Handicapped Child

By Julian D. Boyd, M. D.

Department of Pediatrics, State University of Iowa, Iowa City

THE SIGHT or even the thought of a child who is unable to run and play is sure to strike a responsive note of sympathy. There are other children, however, who are as badly handicapped by disease and whose needs are fully as great who have failed to receive as widespread attention because their disabilities are not apparent to the observer. It is important that consideration be given to all children with handicaps due to disease or to deformity.

The pediatrist's interests are directed toward the child as a whole rather than toward his physical disability. The child specialist's work brings him into contact chiefly with children whose handicaps may be termed medical rather than physical—children with chronic disease that directly or indirectly interferes with their normal participation in life. The same considerations, however, will apply basically to all children with chronic physical disability.

If all illnesses were acute, self-limited processes, problems of care would be simplified greatly. During the time of the child's acute illness his obvious disability makes his need for care apparent to all and effort is made to protect him. Even though such illness may precipitate an economic crisis in the home, the emergency usually will be met in one way or another. If the child makes a complete recovery, he usually will soon catch up on the school work he missed. Unfortunately, many relatively minor illnesses project unfavorable effects on the body for weeks or even months after convalescence apparently is complete. In making his adjustment to normal surroundings the patient carries a residual physical handicap of varying degree. When circumstances lead to a shortening of the period of convalescent care or to lessened attention during the period of acute illness, this handicap is heightened; with chronic illness, the problem is much more complex.

Chronic illnesses differ widely in their nature, cause, and residual effect on the patient. Some diseases appear insidiously and may have been operative for weeks or even for years before their existence is suspected. The child with tuberculous infection usually offers no physical evidence of disease until months or years have elapsed. The child born of syphilitic parents may appear free from disease until midchildhood, when the development of severe damage to the eyes, the central nervous system, or other area leads to recognition of his infected state. In the two diseases just cited the continuance of infection over periods of years is the rule, even with early recognition and adequate treatment. If his vital organs have been damaged the patient often carries his infirmity throughout life, even though the causative disease has been cured or arrested.

Heart disease, secondary to rheumatic infection, serves as another excellent example of the persistence of disability. Damage to the heart arises as a complication of a rheumatic infection which usually in itself is rather mild in its manifestations. The patient may even make an apparent recovery without the heart damage

having been recognized. The damage to the heart lessens the functional capacity of the circulatory system, and when the body calls on the heart for greater service than it is capable of performing symptoms of heart failure become apparent. If the child is nursed carefully through his active disease and his protracted period of convalescence there is strong likelihood that part of the damage will be relieved and that his heart will become strengthened sufficiently to perform under reasonable demands in a fairly satisfactory manner. Such a child, however, usually will carry some degree of heart disability for years, if not for life, and should receive suitable safeguards against further disability. If his physical activities can be kept within the capacity of his heart, his handicap will not be apparent. If, on the other hand, he tries to live the life of the normally active child, chronic heart failure may become established and the child remain incapacitated or die at an early age.

Diabetes mellitus represents another type of chronic illness that may lead abruptly to death or more insidiously to degenerative changes in the body tissues. With suitable treatment the disease can be kept under control, permitting the patient to lead essentially a wholesome and enjoyable life, free from outward evidence of his abnormality. Without treatment, the disease as it occurs in the child is almost invariably fatal within a few months. The condition is not curable; at times of other illness or when extra demands are made on the body for any other reason, the severity of the metabolic defect is increased and serious complications become imminent.

If arrangements cannot be made for the maintenance of the necessary regimen, the patient may become critically ill within a period of a few days and succumb, even though his management hitherto has been ideal. His whole manner of living must be designed to permit such a regimen, and the patient must recognize that his disability will persist throughout life. The reward of proper management is radiant health with no evidence of his disability apparent to his associates.

In review, it is apparent that the ultimate outlook for the child with chronic illness will be influenced by numerous factors, many of which are not medical in nature. Of the medical or physical components, the nature of the disease may be the determinant. Some diseases may become completely inactive, leaving eventually an unpredictable degree of damage to vital body functions; here the medical outlook will be based on the degree of disability of the vital function, the ability of the patient to strike a balance between his degree of disability and the demands of his environment, and his opportunity to remain satisfactorily under such a limited regimen. Other diseases, such as childhood tuberculosis, tend to remain quiescent as long as the patient can lead a life free from deprivation, with assurance of measures which will lead to health advancement and avoidance of contact with sources of further contagion. Such an individual need not be limited in his opportunities for social intercourse or for development. Some other diseases, such as diabetes mellitus, lead to a permanent physical disability which can be controlled wholly as long as a stringent regimen of life and of treatment is maintained, but if such treatment is not available it is predictable that complications will arise which eventually will lead to incapacity or to death.

The outlook for the child with chronic illness is determined not only by the type and amount of medical supervision he receives during and after his episodes of acute illness but also by the adequacy of his environment to meet his needs. These needs include both those demanded because of his illness in itself and those which are necessary even for the normal healthy child if he is to be safeguarded against the threat of disability. Even though the child receive the best of medical and nursing care through his period of illness and during convalescence and even later, certain handicaps will arise to limit his future activities, unless specific measures are directed toward them.

Childhood is the period of preparation for adult life. During that time the child must learn to take his place in the world as an independent, adequate, self-supporting individual. He must receive a basic education and in addition must learn to apply this in a practical manner if he is to avoid a state of dependency as an adult. He must learn to be economically and

socially self-sufficient and in addition must be led toward emotional maturity. As a rule these important phases of the child's welfare are neglected when chronic illness is present, and the ultimate handicap from these factors is as great as or even greater in some instances than the medical condition. The individual who has an affliction which in itself would permit fair or even full participation in the activities of life may become permanently displaced from the position he could fill because of social, educational, or emotional obstacles. It is true that many of our adult citizens are handicapped in these regards even though they never have experienced chronic illness, but this should not lessen the concern of those who care for the child who is ill. Many children with chronic physical disabilities can look forward to a life of incapacity and dependence, on the one hand, or to one of participation and of self-sufficiency, on the other, the outcome to be determined by the opportunities which the child is offered during the course of his illness and through his subsequent childhood.

From the viewpoint of the medical scientist it is important to prevent disease and to treat it in such a manner that it is terminated as soon as possible with a minimum of residual damage. With diseases which necessarily are protracted or incurable it is desirable to establish and maintain a regimen of management which will conserve the patient's health to the utmost degree and allow him to lead as normal a type of life as his handicap will permit. The level of medical care attained will depend on several factors. Some diseases can be treated adequately with the medical facilities available through the services of the general practitioner in the patient's home. Other diseases through their nature demand that the services of the specialist be employed either as the consultant or as the director of medical management.

Without exception the child with chronic illness needs medical supervision which extends beyond the acute episodes of his disease; he should be seen regularly by the physician so that a program of health advancement, conservation, and early recognition of complications may be maintained. The nature of certain illnesses makes it important, if not obligatory, that the child be placed in a well-equipped hospital for certain phases of his treatment. Frequently the detailed nursing service required by the sick child makes a greater demand than the average household is able to meet. In other instances the physical, economic, or emotional state in the home makes it desirable that the child be treated elsewhere, if his best interests are to be conserved.

During protracted convalescence it is often preferable for the child to remain either in a convalescent nursing home or in a supervised foster home rather than for him to stay in the environment which contributed to the development of his disease. The physician cannot meet all these problems of medical care single-handed.

Economic factors frequently stand in the way of desirable care, and although these might be met if the illness were self-limited in its nature, the continued drain over periods of weeks, with the prospect of its continuance for months or even years, can lead to the impoverishment of the family which ordinarily would be self-sufficient.

Emotional factors are equally potent in the encouragement of a compromise. The parents or other members of the household may not be willing to subordinate their own interests in the child's company to his ultimate good. Once the child recovers from the outward evidences of his illness it becomes progressively more difficult for the physician to maintain the regimen which he may recognize is necessary for the best interests of the patient. As a result the type of medical treatment which the chronically ill child receives is a compromise between the measures he needs and the level of management which is convenient for his attendants to administer. There is the tendency for treatment to be passive in nature, barely aggressive enough to avoid catastrophe, leading often toward greater disability rather than less. The physician should not be criticized if he fails to insist on measures of treatment which may seem unnecessary to the parent, which call for a prolongation of medical supervision of the patient, or which are beyond the ability of the family to

pay for. All these factors conspire to perpetuate the passive methods of therapy and similarly to perpetuate the patient's disability. When all in the community can come to cooperate in attaining the maximum level of medical service and when resources can be made available by public agencies to care for those unable to pay for the necessary care, this phase of salvage can become increasingly effective.

Medical phases of treatment should not be considered to the exclusion of other factors necessary for salvage. There is a tendency to credit all of the child's disability to his illness, to his physical crippling, or to other medical handicaps. This is a fair assumption in some conditions, yet in all instances the patient's residual handicaps include social, educational, and emotional inadequacies or maladjustment. Frequently these outweigh the physical incapacity as a cause of enforced invalidism.

During his illness the child is torn from his previous contacts. He becomes as dependent on his environment as an infant. Sometimes pain and suffering are components of the new world in which he finds himself. Prolongation of such a status serves to widen the gap between the child who was well and the child who is ill. After such experiences it is not easy for the child to return to his previous habits of independence and of activity even though his recovery from illness is complete and permanent. It becomes necessary for him to make new associates or rediscover his old ones. Often he loses out on his school work so that he must join the ranks of younger children. Loss of interest or the continued regimen of medical care makes it easy for him to discontinue his schooling. Failures and frustrations mold his outlook, readily leading to the establishment of a sense of defeat.

His handicap may be relatively minor, yet circumstances lead to its exaggeration because of the failure of his attendants to utilize measures for salvage during illness and convalescence. When such a child reaches adulthood he has little chance to overcome the disabilities induced through his medical condition, his unfamiliarity with a vocation, his defeatism, and frequently his precarious economic status. Even with a good capacity for normal physical activities, his situation is not one which is favorable toward the establishment of the usual pattern of adult life. The situation surely is ironic, when medical treatment permits the continuation of life, yet socioeconomic forces prevent normal participation in its activities.

Obviously the regimen of treatment of the child with chronic illness should be designed to assure a minimal degree of physical handicap and the maximum salvage or development of the child's social capacities. Other agencies must operate in teamwork with the physician if the objectives of the plan for salvage are to be realized. Yet how often are these other agencies made a part of the plan of treatment for the handicapped child? The usual procedure is to deal passively with the situation, accepting the child's ultimate state as inevitable. Even the exceptional child seldom receives the special attention he warrants; in most instances the salvage potentialities are not even considered.

A satisfactory program for the discovery and treatment of chronic illness in children would begin with the routine physical examination of well children by pediatrists so that disease could be recognized in its incipiency. Next, the ideal program would include an appraisal of the child's environment, as to the manner in which it has contributed to the child's unfavorable status and as to the likelihood of correction of undesirable conditions. Third, it would provide a plan for supervision of the child's welfare until the disease had been cured or the patient had achieved his maximum recovery. Fourth, it would aid in the attainment of optimum facilities for treatment of the child during active illness and subsequently during convalescence. Last, it would offer an interpretation of the child's needs, capabilities, and ultimate outlook to the parents and the nonmedical agencies concerned with childhood, so that they could work toward a plan for living which would be within the child's capacity.

The foregoing plan admittedly is idealistic, but it is not beyond reason or attainment. It does not call for a quality of medical attention different from that generally available; it calls primarily for a breadth of vision and an integration of the work of agencies concerned with the child. However, it places upon the physician the burden of initiative and interpretation.

When the child is obviously ill, all agencies and individuals look to the medical attendant for direction, and other activities are subordinated to the management of the illness. If the physician confines his thought and attention to the strictly medical phases of treatment of the current illness, treatment may lapse during the subsequent phases of the disease and the patient lose all the ground he previously has gained. If the physician fails to make the parents and the educators partners in planning the child's subsequent activities, either the child's training may be neglected or the encouragement of overactivity may lead to irreparable damage to his physique. Once the spectacular phases of the disease have run their course or have become accepted by the parents and the patient, it frequently is difficult for the physician to maintain the requisite level of care. All factors conspire to encourage a fatalistic attitude toward the patient's disease, with the result that the ultimate outcome depends more on the patient's inherent capacity for health than on the nature of the therapeutic regimen.

The best results will be realized only when the physician and parents work actively on a program of betterment of conditions and do not merely attempt to stem the tide of the disease. If the problem of salvage is kept in mind at all times, much can be accomplished for the habilitation of the child with chronic illness, even under the most adverse conditions.

During periods of protracted convalescence, when the activity of the child's mind calls for something to occupy his attention, his program of recreation can be adapted to his educational capacity and needs.

In favored areas of this country the public-school system cooperates in the activities of some of these children. When the patient's participation in school work is made impossible because of physical limitations, special arrangements are made to lessen the demands for physical exertion or to permit schooling through the visiting teacher, through radio connection with the classroom, or by other means. It is even more important for a child who will carry a handicap of physique or of disease throughout life to be assured of the means for meeting life's problems than it is for the child who is fortunate enough to have high physical capabilities. With adequate training many of our medically handicapped children can become partly or entirely independent. Without it and in the absence of special ability it may be predicted that they will become charges on their relatives or on the community.

The skilled social worker, the public-health nurse, the visiting teacher, and the child psychologist can assist the physician in the integration of the child's care so as to meet his needs in their entirety. Unfortunately many areas do not have such skilled workers available, or the local needs are such that the activities of the experts are fully occupied meeting problems of emergency relief. In such a situation constructive activities often are overlooked.

Comparison of the facilities necessary for proper care of the child with chronic illness with those which are generally available will give a concept of the extent of the problem.

In summary the chief needs for an adequate program pertain to the provision of skilled personnel, physical equipment, integration of facilities already available, and the development of a positive philosophy of attack. Cooperative effort of the whole community and the State is essential to the best results in the care of the handicapped child. Medical service of acceptable nature is usually attainable through some means or other if provision is made for meeting the cost and if resources are known. Hospital care and the cost of medical care must be provided from voluntary contributions or from public funds; also the services of workers especially trained to meet the child's needs—the social worker, the public-health nurse, the nutritionist, and the visiting teacher.

We have a long way to go before effective measures for safeguarding the child with chronic illness can become universally available. Until that time comes, human life and efficiency will continue to be squandered. While this problem of salvage is being attacked, other avenues of study are being directed toward means for prevention of these diseases. As our awareness increases, we come to recognize that much of the misfortune which often is considered inevitable is merely a reflection of the passive, fatalistic attitude of human nature.

The Family Physician Cooperates With the Health Department

By T. R. Meyer, M. D., Dr. P. H.

St. Louis County (Mo.) Health Commissioner

Countless persons reflect the attitudes of their family physician in their ideas and conclusions on public-health matters. Every physician to whom his patients look for advice on matters of health thus becomes a protector of public health and an educator of the public. It is the aim of the St. Louis County Health Department to utilize in our public-health program the family physician and the respect that he rightfully commands.

The success of any examination of small children is dependent on the presence of the parent in order that the physician may discuss with the parent the findings of the medical examination and the corrective procedures recommended. This has not been successfully carried out in most school health programs.

For the most part school physical examinations have been casual, superficial once-overs of children run like an endless belt or conveyor past the school physician. If the parents are not present, as usually is the case, a notification is sent advising Mrs. Smith "that Robert was examined this day by the school physician; that the defects marked with a cross were found; and that Robert be sent to the family physician for correction of these defects."

The results of the stereotyped school examination programs have been poor. A review of the statistics reveals that only 3 or 4 percent of the defects recorded are corrected by this procedure; this means that if the children from one year's third grade were reexamined in the fourth grade the next year, about 95 percent of the same old defects would be found, plus some new ones.

Moreover, when parents in the conscientious 3 or 4 percent go to the family physician as a result of the examination and tell the man who got up one cold December morning to bring Robert into the world (and probably knows better than any one else Robert's physical make-up) that the school physician says Robert should have his tonsils removed no wonder the family physician "blows up!" If he points out that Robert's general condition in his opinion does not indicate a tonsillectomy at this particular time, confusion results; and confusion does not enhance the respect of the public for the medical profession.

During the past 3 years the St. Louis County Health Department, in cooperation with the Medical Society of St. Louis County, has taken an entirely new approach in the handling of physical examinations of school children. The plan was suggested by the health department and endorsed by the medical society and has been carried out in 1937, 1938, and 1939.

The first step was to change the term "physical examination" to "medical examination." Many persons, including nurses and physical-education teachers, may be capable of making what they might term a "physical examination." Only physicians (M. D.'s) are eligible to make a medical examination.

The second step was to transfer the examinations from the school to the family physician's office. There are various reasons for this, the chief one being that young children cannot go alone to the physician's office but must be accompanied by their parents.

Through the cooperation of the Medical Society of St. Louis County 143 physicians have agreed to make medical examinations of entering school children in their offices at designated hours.

St. Louis County, with its approximate 500 square miles, includes not only several cities but territory as rural as the Ozarks. In the urban schools examinations are offered to children entering kindergarten, but in rural schools that do not have kindergartens children entering the first grade are examined. In this paper "entering school children" include children in kindergarten and in the first grade who have not attended school before.

The question of how often a school child should be examined is now under consideration, and it is hoped that present facilities for examination of entering school children can be extended to children in a higher grade, possibly the fifth, and to children entering high school.

A list of the participating physicians with their addresses and their office hours for examinations of school children is supplied to parents.

All the family physicians participating in the plan give medical examinations to entering school children without charge, regardless of the family's ability to pay. The child presents an identification card with a medical-examination certificate on the reverse to be signed by the physician.

The medical-examination blanks, with which each participating physician is supplied in duplicate by the health department, are made up simply and inexpensively in mimeographed form. The copy to be returned to the health department may be mailed in or handed in by the physicians, of whom some are on the staff of the county hospital and some come to the hospital to use the laboratory services. The remainder of the certificates are collected by the district nurse periodically.

Payment for corrective work is made to the family physician by parents who are able to pay. If the physician believes the parents unable to pay he has the prerogative of referring the case to the health department, which arranges with the county hospital for necessary corrective medical or surgical care. In this connection the commissioner of hospitals of St. Louis County has made the services of the hospital social-service staff available, and they have worked out jointly with the health commissioner and his staff forms and blanks to be filled out by the family physician for all applicants for hospital care.

Results of the St. Louis County program, as indicated in the first 3 years of operation, are:

1. Education of parents to take their children to a physician's office and to establish early in their children's lives the habit of seeking medical supervision.
2. Correction of physical defects in an increasingly high percentage of cases.

In one group of 709 entering school children who were examined last year by private family physicians in their own offices the results are rather striking: 644 parents, approximately 91 percent, were in attendance at the examinations. The only defects recorded for this group of children studied were those of a serious nature. Of the 278 serious defects found among these 709 children, 183—a total of 66 percent—were corrected: 44 percent of defects of tonsils and adenoids; 89 percent of dental defects; 72 percent of visual defects; 97 percent of skin defects; 66 percent of nutrition defects; 38 percent of hernias; and 40 percent of orthopedic defects.

Negotiations are under way with the Dental Society of St. Louis County to extend a program to school children through the family dentist's office similar to that which has been so satisfactorily worked out with the medical profession.

The same principle of medical participation of the family physician is utilized in every other phase of our local health program. In other words, a program of medical participation is applicable to contagious disease, tuberculosis, venereal disease, and particularly to maternity hygiene.

Prenatal and postnatal supervision is given through the maternity clinic to all women who are unable to pay for the services of a private physician. A medical social worker on the hospital staff determines eligibility for clinic services and begins a clinical history, which is used in the maternity and all other hospital clinics in order to give a complete picture of the patient's physical condition. The combined opinion of the family physician and the clinicians of the maternity clinic determines whether a patient is to be referred to the county hospital for delivery or delivered at home by the family physician. All normal multiparas whose homes are adequate for a home delivery are referred directly back to the family physicians of their choice for delivery services and postpartum care. If the family physician wishes to do so he may refer his patients back to the maternity clinic for postpartum examinations and any necessary follow-up care. The health department has worked out with the county medical society a plan for a fixed financial contribution to the family physician toward his fee for home deliveries in this program. During the years 1938

and 1939 under this combined arrangement of home and hospital deliveries 1,218 deliveries were made without a single maternal death.

Incidentally, a clinic for expectant fathers has recently been added to the health-department activities. Each registrant receives a physical examination and a serological test for syphilis.

On the basis of our experience with health programs in which the family physician participates we are convinced that the organized medical profession can make a material contribution to the improvement of public health. We have found that our program of medical participation in public-health work is beneficial to the public, the physician, and the health department.

BOOK NOTES

Recent publications in the health field Among recent reports and publications in the field of public health the following have been received:

Advances in New York City's Health. Annual Report of the Department of Health of the City of New York for 1939 with a review of developments from 1934 to 1939. (New York, October 1940. 296 pp.) During the 6 years of progress summarized in the opening section "infant mortality rates attained new lows, decreasing steadily from 53 per 1,000 live births in 1933 to 37 per 1,000 live births in 1939. The puerperal death rate decreased from 6 per 1,000 terminated pregnancies in 1933 to 3 per 1,000 terminated pregnancies in 1939. In this period the lowest general death rate in the city was recorded. . . . Diphtheria deaths decreased from 86 in 1933 to 22 in 1939."

Healthful Living Through the School Day and in Home and Community (State Department of Public Health, Santa Fe, N. Mex., September 1940. 103 pp.). This is a revised edition of Healthful Living Series, Bulletin No. 1, prepared for the use of teachers in New Mexico.

A Tuberculin Testing Program in a School System of About 10,000 Pupils, by W. N. Braley, M. D., Health Officer. (City of Highland Park, Mich. Processed.) Methods of public education included a poster used by theaters, a steady stream of newspaper publicity, and a radio discussion of the value of tuberculin testing, all of which are given full presentation in this report.

Manual for the Conduct of Classes for Expectant Parents. (Cleveland Child Health Association, Cleveland, December 1939. 137 pp. $1.)

Educational Programs for Expectant Parents; analysis of replies to a questionnaire survey. (Cleveland Child Health Association, October 1939. 73 pp. 50 cents.)

Recent bibliographies The library of the United States Department of Labor has compiled a mimeographed list of selected recent references on The National Health Program and Medical Care in the United States (Washington, June 1940. 25 pp.).

A Selective List of Periodicals of General Interest Published in Latin America, 1940, has been compiled by the Division of Intellectual Cooperation of the Pan American Union (Washington, 1940, 30 pp. Mimeographed.). Periodicals published in Spanish, Portuguese, and French are included, with an indication as to the type, policy, and quality of each.

* * * * *

FETAL AND NEONATAL DEATH, by Edith L. Potter, M. D., and Fred L. Adair, M. D. University of Chicago Press, Chicago, 1940. 207 pp. $1.50.

The need has long been felt for a manual of pathology dealing with the fetal and neonatal period. This book, in addition to dealing with techniques and interpretation of special pathology, contains a chapter on trends of births, stillbirths, and neonatal deaths for the United States and tables showing the causes of fetal and neonatal deaths determined in the course of pathologic studies made in the Chicago Lying-in Hospital by the authors, as well as the findings of other investigators in this field. Bibliographical references follow each chapter.

An unusual contribution is the second chapter (57 pp.) on the normal fetus and infant with a detailed discussion of organ structure and development during fetal life. The third chapter describes the methods of postmortem examination with emphasis on the importance of using a technique that will give "the best exposure of the structures to be inspected," and on the need for a complete examination and for keeping accurate records of findings. Several diagrams and photographs illustrate important points in this section.

In the fourth chapter the chief causes of fetal and neonatal death are discussed from the etiological standpoint with reference to data from medical literature as well as to the authors' material. Special pathology is taken up in chapter five on an anatomical basis with emphasis on the lesions of the central nervous and cardiovascular systems. A page of diagrams demonstrates clearly some of the commoner disturbances of circulation due to persistence of fetal circulation or to defects in the heart or vessels.

This handbook should prove valuable to physicians, especially obstetricians and pediatricians, and, of course, pathologists and should stimulate more careful and complete postmortem study of stillborn infants and infants who die in the neonatal period.

E. C. D.

THE PUBLIC HEALTH NURSE AND HER PATIENT, by Ruth Gilbert. Commonwealth Fund, New York, 1940. 396 pp. $2.25.

This book, written by a public-health nurse who is also a psychiatric social worker, deals with the integration of mental hygiene with public-health nursing.

Public-health nursing is broadly interpreted to mean "not only the actual services of the nurse in the field but other relationships and activities of her professional life such as the planning of her work, supervisory relationships, and relationships with other workers—all of which merge in the long run in service to the individual and the family. Administration and program as well as performance sum up public-health nursing."

Mental hygiene is considered not so much as an additional type of service and function of public-health nursing as an enrichment of the quality of public-health-nursing services through greater understanding by the public-health nurse of the attitudes, relationships, and behavior of the nurse herself, of the recipients of her services, and of her co-workers in and outside of the public-health-nursing agency.

Nearly one-third of the text pages are concerned with the maternity patient and with the child. The chapter on the Nurse and Maternity Patient is designed to make the nurse aware of the emotional reactions to pregnancy encountered in women under varying circumstances and at each period of pregnancy.

In the chapter, The Child in His Family, without repetition of basic material on child care and development which is readily available elsewhere, the author suggests some of the points at which developmental research may be applicable to child-health supervision by the public-health nurse under medical guidance. She discusses the relationship between the child's maturation, his developing abilities and skills, and certain phases of personality development and behavior, such as self-assertiveness, destructiveness, thumbsucking, and learning to talk; many familiar training situations; and, briefly, problem behavior.

Subject index and bibliography are appended.

H. H.

PUBLIC HEALTH NURSING IN OBSTETRICS, PART I. Maternity Center Association, New York, 1940. 83 pp. 50 cents.

The Maternity Center Association of New York plans to publish three booklets under the title, "Public Health Nursing in Obstetrics." Part I, which has recently appeared, brings together in an easily available form information which should be of value to the public-health nurse. The facilities for obstetric care in the United States are summarized briefly in the first section, with pictographs showing that, where good obstetric care is available, some maternal deaths are prevented. Terms commonly used in obstetrics are defined and discussed in the second section.

What constitutes good obstetric care is discussed in the third section. Here, good obstetric care is used in its broadest meaning as including "marriage counseling—instruction, counsel, and health promotion, before and after marriage, to help men and women make a success of marriage for their own and their children's sakes." In addition, all the components that constitute safe care throughout the maternity cycle are outlined.

The fourth section, The Local Situation, covers half of the book and is devoted largely to forms and questionnaires designed to give a complete picture of all factors in the care of mothers and newborn infants in a community.

N. D.

FOOD FOR HEALTH IN PEACE AND WAR. Canadian Medical Association, 184 College Street, Toronto, 1940. 19 pp.

What Canadian doctors suggest for wholesome meals at low cost is outlined in this pamphlet, which is receiving wide distribution to families throughout Canada. The Canadian Dietetic Association assisted in the preparation of the food lists, which were tested by Canadian families under the supervision of the Visiting Homemakers Association.

The Children's Bureau *does not distribute* the publications to which reference is made in THE CHILD except those issued by the Bureau itself. Please write to the publisher or agency mentioned for all others.

272110—40——2

• CHILD WELFARE •
• SOCIAL SERVICES •
• CHILD GUIDANCE •

Home-Saving Through Housekeeper Service

By Juanita Venrick Perkins

Colorado State Department of Public Welfare, Denver, Colo.

"I want to keep my girls with me, but I just can't do it. I certainly have tried, but I guess I'm beaten." Mr. Edstrom spoke despairingly to the child-welfare worker as soon as he had been introduced to her by the public-welfare director of the county.

"Do not say that you are beaten. Sit down and we will talk the situation over together," the child-welfare worker suggested with a smile.

Mr. Edstrom seated himself across the desk from her and then continued. "You see, ma'am, their mother is dead; she died 2 years ago of pneumonia, following an operation. I was working as a salesman at that time and my salary and commission averaged around $200 a month. There were large hospital bills, doctor's bills—the funeral took just about all we had saved. Then, last year," and he smiled wryly, "I lost my job."

"Are you working now?" the child-welfare worker asked.

"Yes, I'm working on WPA, and have been for the last 8 months. I'm certainly glad to have it, too. I was just desperate for a job before I got this. I wanted to make enough to take care of my three girls and to hire a housekeeper to look after them, but it's no use."

"What do you mean when you say, 'It's no use'?"

"I've paid as much as $50 a month for a housekeeper and as little as $15, but it doesn't make any difference; I haven't been able to find one who thinks of anything or anyone but herself," he explained. "We're without a housekeeper now and instead of trying to get another one, I thought perhaps I'd talk to you about one of the boarding homes I'm told you have. I know I can't pay room and board for all three of the girls and keep myself, too, but I thought maybe you could suggest something."

"You say you have three girls; how old are they?"

"Lela is 11, Mildred is 9, and Mae is 6. They are healthy and nice, too, if I do say so myself. I wish their mother could see them." His voice broke.

The worker, sensing the strong tie between the father and children and realizing the value of keeping this family unit together, said: "Perhaps I could find a mother who would come into your home and would supervise your girls just as she would supervise her own children. Would you like that?"

"No, ma'am, I just couldn't endure seeing anyone assume their mother's place in my home. It would be different if they were in a boarding home; I couldn't see it then." He hesitated—"You see, I promised my wife that I would be both a mother and a father to the girls and that's what I intend to be," and a defiant light gleamed in his eyes. "All I expect of a housekeeper is someone to look after the children when I'm working, to keep the house clean, and to prepare the meals."

Here was an average father—fearful and apprehensive lest a woman entering his home act as a mother substitute to his girls. The worker talked to him at length of the part the mother and father each play in family life and of the difficulties parents encounter even in normal homes when both parents assume their respective duties. When it is necessary for one parent to assume the dual role, it is even more difficult.

The responsibilities of the housekeeper were listed as covering matters of household management but the sharing with the father in the training and guidance of the children was stressed as being of even more importance. It was emphasized that the training of Mildred and Mae should include instructions in household tasks and in personal cleanliness. Because Lela is older, the housekeeper should assume the role of teacher, training her to assume, eventually, the entire responsibility of the home.

It was further pointed out that the father would be in partnership with the child-welfare worker and that he and she, with the housekeeper, would plan together for the family. In this connection, there was a discussion of time off for the housekeeper. It was decided that one afternoon during the week in addition to each Sunday afternoon would be satisfactory. This would enable the housekeeper to have a life independent of the Edstrom family.

"If I decide to try this, where can you get a woman such as you have described?" Mr. Edstrom asked doubtfully.

"I have several in mind," the child-welfare worker said, and then an understanding smile crossed her lips. "I see you are wondering about it, I'll explain. The child-welfare worker studies a prospective housekeeper

as carefully as she does a prospective foster home. After the study is completed, she submits her recommendation, with the study, to the State director of child welfare for final approval or disapproval. If approval is given, the housekeeper is notified that she has been accepted. Before we consider a housekeeper for this position, however, I think we should first consult your daughters to see if they will accept or resent a woman coming into the home to be like a mother to them."

"That's been one of the troubles," replied Mr. Edstrom. "Lela complained that the women never did things in the manner that their mother did them and no matter how hard some of them tried it was never right."

The child-welfare worker explained that it was his job to interpret the housekeeper to the children and to explain her responsibilities to them and theirs to her. It was emphasized that it is only natural that children have a feeling that the home is theirs and they do not need to obey a stranger in it.

"A woman such as you describe would expect more than $15 a month and that's all I can possibly pay. To tell you the truth, $15 is a great deal more than I can afford." Mr. Edstrom spoke in a matter-of-fact tone.

A budget was prepared and Mr. Edstrom's monthly income, expenses, and debts were listed. It was shown that he would not be able to contribute anything toward a housekeeper's wages without depriving the children and himself of the bare necessities. The child-welfare worker explained that if, after talking to the children, it was decided to try this plan, the Child Welfare Division could use its money to keep a home together by placing a housekeeper in it, as well as to pay board for children outside their own homes.

This was a new idea to Mr. Edstrom. After it had been fully explained to him he was eager that she visit his home, meet his daughters, and endeavor to arrange for a housekeeper.

A visit to the home revealed that the Edstroms had the minimum equipment in household utensils and supplies. There was an enclosed sleeping porch, which could be converted into a bedroom, thus giving the housekeeper privacy and affording the family an opportunity to be alone. Heretofore the "hired woman" had slept on a cot in the kitchen or on the davenport in the living room. The five-room bungalow with sleeping porch was comfortably furnished but ill-kept.

Mrs. Brown was the housekeeper selected as the one who was best equipped to do the job. The child-welfare worker explained the situation to her and prepared her in the same manner as she had prepared the father and children for the roles they would be required to assume. The practical details involving the planning of adequate and wholesome meals on a very limited budget and of keeping house with less equipment than that to which she had been accustomed, were thoroughly discussed. It was further explained that the child-welfare worker did not expect her to become adept in handling all the problems at once, but a realization of factors and a willingness to ask assistance with problems as they might arise, would be expected. If the children manifested signs of hostility, she was cautioned to be very tolerant, inasmuch as the antagonism, in all probability, would not be directed toward her personally. The housekeeper indicated she would be willing and able to take supervision from the child-welfare worker. Arrangements were made for her to meet the father at the office of the child-welfare worker and to discuss matters with him. The child-welfare worker emphasized that the father was a partner in this plan and even though the Child Welfare Division would be paying her for her service, this was his home and he its rightful head.

The child-welfare worker saw the father in her office and described Mrs. Brown to him as a widow in her late fifties who had successfully reared two daughters. They are now married and have children of their own. All members of these families are delighted to have Mrs. Brown visit them. She, therefore, spends as much time as possible in their homes. The child-welfare worker had been in one of the homes during the absence of the parents and she had observed Mrs. Brown handling her grandchildren in a calm, well-balanced manner when discipline was necessary. The child-welfare worker further observed that Mrs. Brown was free from worry; therefore, it was felt that her full attention could be devoted to the Edstrom family. Since her husband's death 5 years before, Mrs. Brown had served as housekeeper in two homes. Both families highly recommended Mrs. Brown as a woman of pleasing personality who got along well with children and was a good cook. The child-welfare worker pointed out to Mr. Edstrom the fact that Mrs. Brown was 15 years older than he, and this would make the situation more acceptable to him and the girls—the housekeeper would not be a rival for the mother's place.

When the father interviewed Mrs. Brown later, she was accepted, and the three-cornered plan, which had been so carefully devised by the father, the housekeeper, and the child-welfare worker, was put into operation.

Mrs. Brown has been in the Edstrom home for 4 months and, during this time, some difficulties have arisen which, in all instances, have been solved through conferences of the father, the housekeeper, and the child-welfare worker. Mrs. Brown has been invited to join the parent-teacher association and is already active in the home-demonstration club of the community.

On the 14th of June Lela sat with the eighth-grade graduating class beautifully dressed in white organdie. As soon as the last diploma had been presented, Mr. Edstrom sought the child-welfare worker, who was talking with Lela's teacher. With eyes glistening with pride and a voice filled with emotion, he said: "Doesn't Lela look lovely? Mrs. Brown made her dress—I was afraid to hope that our plan would work out—but it certainly has." He started away, then came back.

"There's another man working with me who is going through the same thing I was when I met you. May I bring him into your office next week?"

To this story, which appeared in the quarterly publication of the Colorado State Department of Public Welfare for April–June 1938 under the title "Their Own Home," a sequel can now be added:

Mrs. Brown remained in the Edstrom home for 1 year. During this time she trained the three girls in desirable home duties and personal habits in keeping with their age. With Lela, the oldest, she assumed the role of teacher, training her to take over eventually the entire responsibility of the house. However, the father's remarriage in 1939 made it unnecessary for Lela to assume this responsibility.

In evaluating the year of housekeeper service afforded this family, the father and the child-welfare worker mutually concluded that such service had (1) made it possible for him to continue to maintain a home for his girls so that family ties between father and children could be preserved; (2) enabled Lela to finish the eighth grade; (3) provided much-needed training and a "mother's influence" during their early adolescent years; (4) prepared them well for adjustment to their stepmother.

Housekeeper service has been used frequently under the program of Colorado child-welfare services to keep family units together where for one reason or another, either temporarily or permanently, the mother is unable to assume the responsibility in the home. The following four classifications represent the kinds of situations in which housekeeper service has seemed most useful.

The first group includes families in which the mother is permanently out of the home, either through death as in the Edstrom case or through institutionalization. If the father in such cases is closely tied to the children and the background of the family is as stable as the average, housekeeper service has proved most satisfactory.

The second group includes families in which the mother is out of the home for an indefinite period—in a tuberculosis sanatorium, say—but with a hope of returning some time in the future. Here a slightly different element enters into the plans, as not only must the family unit be preserved but the home must be prepared for the ultimate return of the mother.

A third group is formed by families in which the mother is in the home but permanently an invalid. Here the attitude of the mother is the vital and deciding factor in the situation.

The fourth group comprises the families in which the mother is temporarily out of the home or temporarily unable to assume the responsibility if in the home. This last group represents the least urgent claim for housekeeper service, and in some instances maid service has been utilized successfully.

Under these four classifications the Division of Child Welfare has employed 17 housekeepers in 18 families during the last 2 years. The length of employment in any one family ranges from a temporary placement of 1 month to permanent placements of 2 years in which employment will be continued until the oldest girl can assume responsibility or there is some other change in family relationships making housekeeper service unnecessary. Housekeepers who prove satisfactory after the first probationary placement are moved from one family to another wherever the need exists. By selecting women who are free to move into new communities the agency is able to assure permanent employment to a certain number of women and to build up a register of capable housekeepers.

Although housekeeper service has been used in seven rural counties in Colorado, most of the housekeeper-service program is concentrated, as it should be, in counties that have a full-time child-welfare worker with professional training. For in some ways the case worker's role in housekeeper service is the most difficult in this three-cornered arrangement between the father, the housekeeper, and the case worker. Knowing more about the working out of such arrangements and not being involved emotionally in the situation, she has the responsibility of helping the others to see their individual problems and how they are interwoven.

Recruiting housekeepers has proved a difficult task in rural communities. For it is the unusual person who has any conception of a housekeeper other than as a dependable "hired woman." So in each county it has meant a careful differentiation between the types of responsibility involved in being a maid and in being a homemaker. It has also meant that the child-welfare

workers have been swamped with referrals and applications of women who are laid off of work programs periodically and see this housekeeper program of child-welfare services as another work project.

It has proved helpful to explain to county welfare staffs, advisory boards, and service groups some of the difficulties the child-welfare worker incurs in the selection of a person capable of filling the position of homemaker in a motherless home. Many women seeking a housekeeper's position may be motivated by the need for a job and a natural love for children without recognizing the emotional factors involved in the acceptance by any family of someone to take the mother's place in the home.

Although there has been some need for housekeepers for day service as well as for those who live in the home, it has been difficult to work out day service in rural areas in this State where distances are great and means of transportation scarce for individual rural families.

In the 18 families in which housekeeper service has been used home and family ties have been preserved for 65 children. Thus housekeeper service is a device that has proved very useful in helping to maintain "for every child a home and that love and security which a home provides."

Award for Service to Children Goes to Miss Lenroot

In connection with the observance of Better Parenthood Week, September 23–29, the 1940 award offered by *Parents' Magazine* for outstanding service to children was given to Katharine F. Lenroot, Chief of the Children's Bureau. George J. Hecht, chairman of the Better Parenthood Week Committee and publisher of *Parents' Magazine* declared that Miss Lenroot was awarded the medal for 26 years of outstanding service and "because she is known in this country and abroad as the best friend of America's children."

Miss Lenroot, in accepting the medal, said:

> The present emergency makes it important that we press forward to provide our children with decent homes, nourishing food, health service and medical care, schooling that prepares for citizenship, and protection against child labor. The American people have resolved that the lives of mothers and babies are not to be needlessly sacrificed and that the health, education, and welfare of the younger generation are matters of national as well as local and parental concern.

BOOK NOTES

BORROWED CHILDREN, by Mrs. St. Loe Strachey. Commonwealth Fund, New York, 1940. 149 pp. 75 cents.

The evacuation of children from English cities to rural parts of England in September 1939, some of the problems encountered, and their remedies are described in this small book, which was first published by John Murray, London, in July 1940.

How They Came and What Has Happened Since are the self-explanatory titles of the two main parts. The case material presented is the result of the planned work of the Mental Health Emergency Committee, representing five societies interested in psychological problems. This committee set up a register of social workers with training in mental health and organized emergency child-guidance clinics to which foster parents and "hostesses" of "billeted" children could come for help with children who were not adjusting themselves satisfactorily to their new situation. Some of the problems dealt with grew out of unfavorable situations in the homes from which the children came; others were the direct result of the uprooting and separation inherent in the fact of evacuation. Many instances are given of anxiety resulting in enuresis or stealing.

The clinic workers were able to clear up many of the situations by bringing about better understanding between child and foster mother and thus increasing the child's feeling of security. In some cases the child was rebilleted with a less exacting family. A home was opened for children who were unable to fit into ordinary homes; 20 children at a time lived in this home, which supplied a favorable environment and direct treatment.

One chapter, "Running Wild," describes the plight of some 800,000 children in cities where schools were closed who were not evacuated or who returned to their homes after evacuation and who were listed by the school authorities in March 1940 as "unaccounted for."

This brief report points up vividly the problem of adjusting children and billet-parents which had to be met and which has many implications for those in the United States who are caring for child refugees.

THEORY AND PRACTICE OF SOCIAL CASE WORK, by Gordon Hamilton. Columbia University Press, New York, 1940. 388 pp. $3.

The author states in the preface that she has not attempted to offer a wholly new interpretation of case work but that she does attempt to analyze and reconcile some of the more significant elements of theory and practice today. In chapters 1–10 consideration is given chiefly to the general aspects and in chapters 11–14, to the functional adaptations of social case work.

The theory of case work is discussed and illustrated by case material presented in great detail. Case illustrations have been drawn from records of clinics, courts, hospitals, public and private social agencies—particularly family and children's agencies.

1940 YEARBOOK, PARK AND RECREATION PROGRESS. National Park Service, U. S. Department of the Interior, Washington, 1940. 92 pp.

Illustrated with photographs, maps, and drawings, this yearbook contains articles by authorities in the park-service and related fields. Camping, bicycling, recreational-area planning, recreation as a by-product of reclamation, and the role of the museum in public recreation are among the subjects covered.

THE JUVENILE LAWS OF CALIFORNIA; including Federal statutes, by Joseph F. Triska, LL. B. Research Publishing Co., Los Angeles, 1940. 349 pp. $5.

All the laws of California that relate to minors are presented in readable form, classified by subject: Parent and Child; Legitimacy; Adoption; Education; Marriage; Employment; Guardianship; Legal Status; State Welfare; Delinquency; Juvenile Court Law; Succession; and Offenses Against Minors.

Under the title, Employment, are classified laws on wages, hours, and working conditions; prohibited occupations; maximum hours and night employment; and apprenticeship.

The chapter on State Welfare includes laws relating to the protection of physically handicapped children; to the commitment of incompetents; to orphanages, institutions for child care, home-finding agencies, institutions for the feeble-minded and for the blind; and to the Children's Court of Conciliation, which has jurisdiction in controversies between spouses having any minor child whose welfare might be affected by disruption of the household.

Appendixes summarize orders issued by the State department of industrial relations which have the force of law and Federal statutes applicable to minors.

The phraseology is simplified for the most part, and code provisions and court decisions dealing with administrative functions and court practice and procedure are omitted.

PARENTS AND CHILDREN GO TO SCHOOL; adventuring in nursery school and kindergarten, by Dorothy Walter Baruch, Ph. D. Scott, Foresman & Co., Chicago, 1939. 504 pp. $3.

The author, who is director of the preschool and parent-education department and professor of education, Broadoaks School of Education, Whittier College, has described in detail what goes on in one preschool composed of nursery and kindergarten groups. Emphasis is placed on the consideration of the whole child, the place of mental hygiene, the necessity for cooperation of the home and school, and the importance of the early years of a child's life.

• CHILD LABOR •
• YOUTH EMPLOYMENT •
• VOCATIONAL OPPORTUNITIES •

Child-Labor Standards and Defense Contracts

By Savilla Millis Simons

Industrial Division, U. S. Children's Bureau

It is a source of great satisfaction to those interested in the protection of children that, in the increased production for defense purposes, a determined effort is being made to maintain present labor standards. The National Defense Advisory Commission unanimously adopted on August 31 a statement of labor policy for the guidance of contractors who receive national-defense orders from the United States Government. Among other provisions this statement calls for compliance both with Federal laws affecting labor, including the Fair Labor Standards Act, the Walsh-Healey Act, and the National Labor Relations Act, and with State and local statutes affecting labor. Through this provision the defense labor policy calls for observance of the child-labor provisions of the Fair Labor Standards Act, which contains a basic 16-year minimum-age standard for establishments shipping goods in interstate commerce, and of the State child-labor laws.

When the defense program first swung into action some public opinion favored lengthening hours in order to increase production. The Defense Commission's labor policy states that "all reasonable efforts should be made to avoid hours in excess of 40 per week" and that overtime rates should be paid "when the requirements of the defense program make it necessary to work" more than 40 hours per week. This espousal of the 40-hour week is highly important not only as a safeguard to the welfare of young workers but as a measure to facilitate absorption of unemployed youth and adults.

Connected with the Defense Commission's labor policy is the new use of negotiated contracts for Government purchases for the War and Navy Departments. On September 6 the Defense Commission adopted a statement of general principles governing the letting of defense contracts which authorized the use of negotiated contracts. This was made possible by a recent enactment of legislation by the Congress, providing for the awarding of contracts "with or without competitive bidding." Formerly the Government was required to buy through competitive bidding; under this system, the award of the Government contract went automatically to the lowest bidder.

Under the negotiated contract a number of factors in addition to that of price may be taken into consideration, including the firm's labor record. Among other factors to be considered in the negotiated contract are speed of delivery, proper quality, health and housing facilities for employees, the avoidance of undue geographic concentration, possible off-season production in order to dovetail the military program with production to meet civilian needs, and the financial and moral responsibility of the firm.

On September 13 President Roosevelt sent both the statement of general principles governing the letting of contracts and the statement of labor policy to Congress for the information of the members. On October 1 Sidney Hillman, Commissioner in Charge of the Labor Division of the National Defense Advisory Commission, made public letters from Secretary of Navy

Knox and Assistant Secretary of War Patterson, stating that contractors would be informed that full compliance with these principles would be expected and that procedures were being formulated whereby the principles and labor standards set up in these statements could be incorporated in all contracts awarded.

The leadership which the National Defense Advisory Commission has taken to insure the maintenance of the labor standards, which have been found over a long period of years to be in the best interests of the Nation, is a sign that in carrying forward this tremendous defense effort, due regard will be given to the well-being of the workers as a means of promoting efficiency in production as well as the general welfare.

I. A. G. L. O. Convention

At the Twenty-sixth Convention of the International Association of Governmental Labor Officials, which met in New York September 9–12, 1940, the report on child labor was given by Beatrice McConnell, chairman of the Child Labor Committee. Miss McConnell is Director of the Industrial Division of the United States Children's Bureau. The report covers progress during the year in child-labor legislation in the United States and Canada, protection of migrant children, regulation of the employment of minors in hazardous occupations under the Fair Labor Standards Act, and issuance of age certificates under the Fair Labor Standards Act of 1938 and the Sugar Act of 1937. It stresses the need for establishing standards and administrative techniques for handling the employment of children in street trades and industrialized agriculture.

It also points out the importance of safeguarding existing child-labor standards in times of urgency such as the present and of giving "the children and youth of this country every possible opportunity for their education and training and for their intellectual, moral, and physical development so that they may be equipped with the necessary ability and zeal to meet the great responsibilities of the coming year."

In line with the child-labor report is the following resolution which the convention adopted on youth labor standards:

> In a program of national defense it is of paramount importance [to the Nation] to safeguard and promote the health, safety and morale of its workers, in particular of its youthful workers, while they are being introduced to industry and seasoned in its processes.
>
> This conference, therefore, emphatically urges that at no point shall there be relaxation of the legal standards that have been built up for the protection of young workers from too early or too hazardous employment, or that otherwise safeguard them on the job or in training.
>
> Attention is called to the fact that experience has shown that such safeguards are not only for the good of the individual but tend to increase production. . . .

Other resolutions reflect the preoccupation of the conference members with problems associated with the international situation and national-defense plans. One resolution welcomes to North America the International Labor Organization, which is transferring a large part of its personnel from Geneva to Montreal. Other resolutions deal with the training of factory inspectors and the extension of minimum-wage systems. A resolution on Central and South American representation extends a cordial invitation to all governmental labor agencies of the Republics and political Divisions and subdivisions of the Americas, islands and possessions included, to become affiliated with the I. A. G. L. O. in order to protect their mutual interests.

Brazil

Regulation of child labor in street trades

Under the Presidential Decree regulating street trades in Brazil, issued February 27, 1940, minors under 18 years of age may not be licensed as street traders on their own account. Minors under 18 may be licensed to be employed in street trades only if they present proof of age, authorization from parent or legal guardian, a physician's certificate of physical and mental fitness, and a certificate of vaccination. (Under the Children's Code of 1927 (sec. 112) no boy under 14 or unmarried woman under 18 may engage in street trades.)

A maximum working day of 8 hours is prescribed for minors under 18 in street trades, and work between 10 p. m. and 5 a. m. is prohibited for children under 16.

Street dealers in foods and drinks must be examined at least once a year by a physician in public service; the license is to be revoked in case of communicable disease.

The decree will be administered by inspectors of the Department of Labor and by the local public-health and police authorities.

Boletim do Ministerio do Trabalho, Industria, e Comercio, Rio de Janeiro, No. 67, 1940, p. 40.

* * * * *

Commission for revision of laws appointed

For the purpose of putting into practice the clauses of the Federal Constitution of 1937, relating to the employment of women and children, the Minister of Labor of Brazil has recently appointed a commission which is charged with the task of examining the existing legislation for the protection of working women and children and making recommendations.

Ibid, No. 68, p. 71.

NEWS NOTES

Puerto Rico designated

Puerto Rico has been designated as a State in which State work permits and age certificates are acceptable as proof of age under the child-labor provisions of the Fair Labor Standards Act. The Insular Department of Labor has been designated as the supervising agency, and the Department of Education and the Health Department on the Island will cooperate also in the general program. The designation became effective September 20, 1940, for the period ending June 30, 1941.

The designation of Puerto Rico brings to 45 the number of States and United States jurisdictions so designated.

Aid to migrants

A report dealing with the social problems of migratory workers and their families and making recommendations for State and Federal action was presented to President Roosevelt in July 1940 by the Interdepartmental Committee To Coordinate Health and Welfare Activities (Migratory Labor—A Report to the President, July 1940; 21 pp. Mimeographed). Its recommendations include proposals for:

A series of State-Federal regional conferences to promote public understanding of the migratory-labor problem.

Federal aid for educational, recreational, and welfare services to communities with large migrant groups.

Expansion of the Farm Security Administration's camps for migratory agricultural workers, and Federal provision for permanent garden homesteads for migrants who obtain year-round jobs on nearby farms.

A Federal-State program, backed by an initial $5,000,000 appropriation under the Social Security Act for the current fiscal year, to provide health and medical services for migrants.

Closer Federal supervision of working conditions for migrant laborers through Federal regulation of interstate-labor contractors.

Interstate Commerce Commission regulation of the transportation of workers across State lines by truck.

Expansion of the farm-placement service.

Extension of wage-hour coverage to agricultural migrants.

Protection for children of migratory workers against employment at too early an age or under unfavorable conditions.

Extension of the social-security programs, including public assistance, old-age insurance, and unemployment compensation to migrants.

To meet the emergency situations that have developed, provision of more effective immediate aid for migrants and their families and of a continuing program of aid through a general relief program established on a Federal-State basis.

The assurance to migratory workers of "the civil rights to which all citizens are entitled."

The recommendations are premised upon closer working relationships and better coordination among Federal and State agencies with responsibilities in the several fields involved.

The Committee recognizes that no public service or protection is a substitute for adequate job opportunities. While it believes the steps indicated are urgently needed, it urges also that continued study and effort be devoted to meeting the basic economic problems in which these and other immediate needs are rooted.

BOOK NOTES

Publications of NYA State offices

Occupational Information Research Reports recently received from State Youth Administrators are as follows:

Aircraft Industry. Revised edition. National Youth Administration for Illinois, Chicago, June 18, 1940. 53 pp. Mimeographed. Job descriptions and qualifications particularly have been treated more comprehensively than in the 1936 edition.

Hosierymaking—Nylon and Silk, by Robert S. Richey. National Youth Administration for Indiana, Indianapolis, May 15, 1940. 25 pp. Mimeographed.

The Railroad Industry, by Lotys Benning Stewart. National Youth Administration for Indiana, Indianapolis, August 1940. 119 pp. Mimeographed.

Tung Oil Production in Mississippi. National Youth Administration for Mississippi, Jackson, May 1940. 59 pp. Mimeographed. This report, which traces the use of tung oil in China back to the days of Marco Polo, was written by John Godbold and illustrated in pen and ink by Florian Nesossis.

The Machine Tool Industry in Ohio. National Youth Administration in Ohio, May 1940. 119 pp. Mimeographed. This report, by Wilbur R. Hanawalt, is illustrated by photographs and drawings, and tells the story of machine tools from the caveman's first handdrill. A chapter on training for machine-tool work contains a description of the apprenticeship system.

GUIDANCE PROGRAMS FOR RURAL HIGH SCHOOLS, by Paul W. Chapman. Vocational Division Bulletin No. 203, U. S. Office of Education, Washington, 1940. 58 pp.

To assist the 17,000 smaller high schools, which for the most part serve rural youth, in organizing vocational-guidance programs is the purpose of this bulletin.

It is divided into four parts. In part 1 is presented the desirability of making vocational-guidance services an organic part of the program of every school; attention is called to the peculiar problems of high schools in rural areas. Parts 2 and 3 are reports of the guidance programs in two school systems in New York State —Newark Valley Central School and the Rockland County schools. Part 4 presents an outline of the functions of the complete guidance service for a local school system. The appendix contains 18 forms used in connection with the guidance services of the Nyack schools (in Rockland County).

YOUTH IN AGRICULTURAL VILLAGES, by Bruce L. Melvin and Edna N. Smith. Research Monograph 21, Division of Research, Works Progress Administration, Washington, 1940. 143 pp.

The school attendance and educational attainment, employment, and occupations of village youth are given a chapter each in this monograph. Other aspects of the life of village youth which are discussed include their mobility, personal characteristics, financial status, and social and recreational activities. One chapter is devoted to economically independent youth away from the villages. The age covered is 16 to 29 years of age, the 25- to 29-year-old group being included in order to show how those who were "near the mid-point of the youth age at the beginning of the depression of the early thirties have made their adjustments." In some of the tables two totals are given—for youth 16 to 24 years of age and for youth 16 to 29 years of age.

Underemployment is emphasized in the summary, rather than unemployment, as the outstanding occupational difficulty among village youth. Nevertheless, when out-of-school youth 16 to 24 years of age are considered, it appears that 13 percent of the boys and 38 percent of the unmarried girls were unemployed at that time. The proportion of young persons of both sexes who were neither in school nor gainfully employed was greatest for the 16-17 year age group (31 percent for the boys and 52 percent for the girls). The survey was made as of June 1, 1936, a period when agricultural

employment was at a high level, and youth were classified as employed if they had worked for pay at least 1 day each week during the 2 weeks preceding that date. Youth engaged in emergency employment were also classified as employed.

FACTORIES IN THE FIELD LURE THE BAREFOOT BOY. New York Child Labor Committee, 105 East Twenty-second Street, New York. 12 pp.

A "sampling" of child-labor conditions on large truck farms in central New York in the summer of 1939, summarized in this illustrated pamphlet, indicated that as many as 10,000 to 15,000 child workers are so employed in the State of New York. Investigators found children 8 years of age and up carrying baskets too heavy for their strength; overcrowded trucks taking children to the field (8 instances of truck accidents in which 19 boys and girls were injured); illness among child workers due to impure water, heat exhaustion, and acute plant poisoning; and cases of children who had been struck by overseers because they were not working hard enough.

• EVENTS OF CURRENT INTEREST •

"Raising a President"

A weekly series of radio programs is being given by the Children's Bureau on the general theme of "Raising a President." These programs can be heard over the blue network, National Broadcasting Company, at 2 p. m., Eastern standard time. The first 13 programs, beginning October 2, 1940, are concerned with various aspects of food and nutrition and consist of a brief dramatization followed by discussion. The subjects for November and December are as follows:

November 6—The Recess Bell! A discussion of school lunches.

November 13—Time Out To Eat; a discussion of food for the whole family.

November 20—Food Dollars and Sense; budgeting for food according to the size of the pay envelope.

November 27—Substitutes for the Sun; selecting foods to take the place of sunlight.

December 4—Grow While You Sleep; the connection between nutrition and sufficient sleep.

December 11—Children and the Defense Program.

December 18—Helping Santa Claus.

December 25—How To Live With Children and Love It!

New Constitution of Paraguay

The new Constitution adopted in Paraguay in July of this year and replacing the Constitution of 1870 requires the establishment of free primary schools with compulsory attendance and directs the Government to promote secondary and vocational education. Among the fundamental duties of the State the Constitution names social aid, the care of the population's health, and physical education of young people.

Laws will be necessary to put these principles into practice.

Official copy of the Constitution.

CONFERENCE CALENDAR

Nov. 10–16 American Education Week. Twentieth anniversary. Information and program material from National Education Association, 1201 Sixteenth Street NW., Washington, D. C.

Nov. 10–16 Children's Book Week. Information and manual of suggestions from Book Week Headquarters, 62 West Forty-fifth Street, New York.

~~Nov. 12–14 Seventh National Conference on Labor Legislation. Called by the Secretary of Labor, Washington, D. C.~~

Nov. 12–15 Southern Medical Association. Thirty-fourth annual meeting, Louisville, Ky. Permanent headquarters: Empire Building, Birmingham, Ala.

Nov. 12–15 American Society of Tropical Medicine, Louisville, Ky. Secretary: Dr. E. Harold Hinman, Wilson Dam, Ala.

Nov. 13–15 National Association of Day Nurseries. Second annual conference, New York. Permanent headquarters: 122 East Twenty-second Street, New York.

Nov. 15 National Council for Mothers and Babies. Annual meeting, Hotel Washington, Washington, D. C.

Nov. 15–16 Child Study Association of America. Two-day institute, Hotel Roosevelt, New York. Permanent headquarters: 221 West Fifty-seventh Street, New York.

Nov. 18–20 American Academy of Pediatrics. Annual meeting, Memphis, Tenn. Secretary-Treasurer: 636 Church Street, Evanston, Ill.

Dec. 4–8 American Public Welfare Association. Annual round-table conference, Washington, D. C. Permanent headquarters: 1313 East Sixtieth Street, Chicago.

Dec. 8–9 Associated Women of the American Farm Bureau Federation. Annual convention, Emerson Hotel, Baltimore, Md.

Dec. 9–12 American Farm Bureau Federation. Annual convention, Baltimore, Md.

Dec. 26–28 American Statistical Association. One-hundred and second annual meeting, Chicago. Secretary: Frederick F. Stephan, 1626 K Street NW., Washington, D. C.

Dec. 27–29 American Sociological Society and affiliated organizations. Annual meeting, Chicago.

Dec. 27–30 American Economic Association and Southern Economic Association. Annual meeting, New Orleans, La.

Dec. 27–30 American Library Association. Midwinter conference, Chicago. Permanent headquarters: 520 North Michigan Avenue, Chicago.

Dec. 27–30 American Association for Labor Legislation. Thirty-fourth annual meeting, Chicago. Permanent headquarters: 131 East Twenty-third Street, New York.

NOTICE!

The Seventh National Conference on Labor Legislation, previously scheduled for November 12, 13, 14, has been postponed to December 9, 10, 11. The Conference, which meets in Washington, D. C., at the call of the Secretary of Labor, serves as a medium for clearance and cooperation among State labor commissioners and administrators and representatives of organized labor appointed by the State Governors.

U. S. GOVERNMENT PRINTING OFFICE: 1940

iatrics.
Tenn.
Church

iation.
erence,
nanent
ixtieth

nerican
Annual
Balti-

ration.
timore,

ciation.
annual
retary:
626 K
D. C.
ty and
Annual

ociation
Associa-
ew Or-

ciation.
hicago.
: 520
hicago.
Labor
th an-
Perma-
East
York.